
Dialectical Behaviour Therapy: A social work intervention?

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Abstract

This article introduces the mental health treatment, Dialectical Behaviour Therapy (DBT) as a dynamic and challenging therapy well suited to a critical social work perspective. From the authors' experience of providing DBT in a tertiary health setting over the past three years, the connections between DBT and social work will be espoused with the central tenet being the demonstration that psychiatric social workers are highly skilled once trained in this modality.

Introduction

Dialectical Behaviour Therapy (DBT) is an internationally delivered, intensive psychotherapy utilised for certain mental health problems. DBT is being increasingly utilised throughout New Zealand and specifically the authors' workplace within a mental health outpatient environment. Because tertiary psychiatric services are the primary contexts for delivering DBT programmes, this article concerns social workers employed in these environments and thus the article directly references psychiatric social work.

DBT has been provided by MidCentral Health in various forms since the year 2000, and in 2006-8, 12 clinicians completed an intensive training programme by BehaviorTech – the official DBT education arm. Four of these 12 are psychiatric social workers. Each clinician is involved in all of the DBT modes of delivery including individual therapy, skills group, telephone coaching and the consultation team. This article is authored by two psychiatric social workers who completed the 2006 intensive training. We introduce DBT as a treatment that is becoming more utilised in mental health fields through multi-disciplinary delivery, and posit that the social work paradigm, training and practice means that social workers in mental health settings are well-placed to deliver it.

In conducting this therapy we have found that our social work background aids our understanding and delivery. Social work values and practices align well with the principle-driven nature of DBT. The aim is to balance acceptance of people as they are; with a change focus where agreed upon goals are set. The aim is to support the client to build a life that is worth living for them. This is achieved through utilising a bio-social and dialectical para-

digm and strategies of validation, radical genuineness, skills training and group work. In this article we will provide a grouped list of generic social work skills and interventions and explore their relevance to DBT delivery so as to present the correlation in both style and practices between social work and DBT.

Dialectical Behaviour Therapy: An introduction

DBT was developed by Dr. Marsha Linehan, a North American psychologist who had been treating suicidal and self-harming populations using a Cognitive Behavioural approach (Linehan, 1993; Marra, 2005). Linehan (1993) developed a text and parallel skills training manual when she found the clients she was working with, many of whom suffered Borderline Personality Disorder (BPD), were not getting positive outcomes, or were dropping out of usual psychotherapeutic approaches. Linehan confirmed the limitations of behavioural interventions previously evidenced in social work practice where to progress in treatment people need acceptance balanced with the change-driven nature of many behavioural therapies (Lew, Matta, Tripp-Tebo & Watts, 2006).

Linehan found those she was working with who were diagnosed with BPD were more sensitive to emotions and perceived criticisms and thus did not manage well when change was pushed or their thoughts treated as distorted without the validation of their emotional sensitivity. This emotional sensitivity develops within traumatic or poor attachment experiences (Linehan, 1993; Marra, 2005). Conversely, if patients were only attending supportive interventions and no change was occurring, both the therapist and client would become frustrated with therapy. The concept of dialectics was introduced to the therapy by Linehan as a way to explore the need to balance treatment approaches such as acceptance strategies and change strategies which appear mutually exclusive but in effect cannot exist without one another.

People with high emotional sensitivity often have life-long experiences of their emotions being disregarded and therefore invalidated, leading to invalidation of the self. Emotionally invalidated clients can thus have grave difficulties with acceptance of themselves and their situations, striving constantly to change problems, even when certain problems cannot be changed. This non-acceptance is characterised by frantic but often unskilful attempts to solve problems in living through self-harm, suicidality and addictive behaviours. Thus, the spiritual aspects of the DBT were developed of radical acceptance and mindfulness. Principles of acceptance within Christianity and Buddhism were explored to create the mindfulness component of DBT. Mindfulness is the total acceptance of the moment, regardless of what is in it, by using full, non-judgemental attention control and participation. Mindfulness is becoming so widespread within therapeutic applications it now has its own extensive literature and research base (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004; Germer, Siegel, & Fulton, 2005; May & O'Donovan, 2007).

DBT has a number of assumptions and principles at its core that are espoused for multiple mental health issues. Of first importance is the paradigm of a dialectical approach. A dialectical approach states that there is no absolute truth as perspectives change and shift (Lew et al., 2006; Linehan, 1993). This approach allows for the gaining of new understandings and the striving for synthesis in apparent opposites or extremes. Further assumptions including the utilisation of a biosocial understanding of emotional lability or dysregulation

(emotional change due to higher sensitivity to emotions) (Lew, et al., 2006) and concepts of validation will be elaborated on further in this article due to their connection with social work practice. The DBT therapist utilises these principles primarily to address problems in emotion regulation systems, the common deficit in the range of disorders DBT is utilised for (Marra, 2005). As Marra states: '[t]he approach is effective for patients who experience intense emotional pain or urges that they attempt to avoid or escape, regardless of the diagnosis' (2005, p.6). Since its development 13 clinical trials have found DBT as the most efficacious treatment currently in place for BPD (Koons, et al., 2001; Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard & Armstrong, 1994; Linehan, Schmidt, & Dimeff, 1999).

While DBT was initially developed for BPD and has been found as the most effective treatment currently for this disorder (Linehan, et al., 1991; Swenson, 2000), additional studies have found DBT effective in youth populations (Miller & Rathus, 2006; Miller, Rathus, Leigh, & Landsman, 1996); substance use disorders (Linehan, Dimeff, & Reynolds, 2002; Linehan, et al., 1999); eating disorders (Telch, Agras, & Linehan, 2002); older persons depression (Lynch, Morse, Mendelson, & Robins, 2003); and more recently intellectual disabilities where people have problems with impulse control and self-harm (Lew, et al., 2006; Marra, 2005). Marra (2005) has extended application of DBT to include use with any mood, anxiety, addictive, eating, impulse-control and personality disorders, seeing these as covering most diagnostic classifications as the western world currently conceptualises them.

Additionally, a DBT programme adapted by Miller and Rathus (2006) for adolescents and their families is in practice within the Child Adolescent and Family Mental Health and Alcohol and Drug Services, MidCentral Health Ltd. Plans to develop the programme to be more responsive to the bicultural needs of Aotearoa New Zealand mental health services as well as adaptations for clients with cognitive impairment are in place.

Social work and psychotherapy

There are many definitions of social work utilised in a range of fora reflecting the breadth of social work practice and skills. A most commonly used definition is that of the International Federation of Social Work (2002):

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

What is common to this definition and across the definitions of social work is a focus upon social justice and human rights through intervening at the praxis of the individual and their social context. Importantly many social work definitions refer to the professionalism of the discipline; the focus upon promoting change and problem solving towards the goal of enhancing wellbeing; and the deliberate execution of theories of human development, personality and behaviour. This becomes significant as we consider the therapeutic aspect of the social worker's role in delivering psychotherapy such as DBT.

The Dorland's Illustrated Medical Dictionary defines psychotherapy as:

... the 'treatment of mental disorders ... using verbal and nonverbal communication, including such psychological techniques as support, suggestion, persuasion, re-education, reassurance, and insight, in order to alter maladaptive patterns of coping, relieve emotional disturbance, and encourage personality growth (2007, p. 1573).

Reber (1988) defines psychotherapy in its broadest sense as 'the use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotion, or behavioural disorder' and notes that that psychotherapy is 'properly used only when it is carried out by someone with recognised training and using accepted techniques' (p.598).

Our premise is that any social worker with a dialectical paradigm and social work and DBT qualifications can deliver DBT effectively and there are psychiatric social workers in New Zealand qualified in DBT delivering comprehensive programmes. What may also be observed from the above definitions of psychotherapy is that many social workers are incorporating psychotherapeutic tools legitimised through evidenced-based therapies such as DBT. These definitions identify both the range of 'any technique or procedure' and the specific skills 'verbal and non-verbal communication' necessary in any psychosocial intervention. Many of these skills in achieving a curative effect are utilised in both social work and DBT practice, such as verbal and non-verbal means of communicating to extend knowledge and insight. These skills' overlaps are reviewed in the next section.

Social work skills in drawing out the client's strengths and the naturally occurring social support networks are integral for creating effective change (Asay and Lambert, 1999; De Jong & Miller, 1995). DBT also specifically attends to client effects and external factors by acknowledging the need to coach the client to access their supports skilfully, allowing the therapist to be more active within the client's environment if the client themselves does not yet have the skills, or the matter is essential to their livelihood (Linehan, 1993). Thus, it may be most effective to have social workers who can hold this wider ecological and strengths-based understanding while following an evidenced-based individual treatment approach such as DBT.

The one area in which DBT and social work practice does not align is in the creation of wider social change – a social work focus that the individual nature of DBT treatment does not incorporate. For the effective social worker a further dialectic emerges: treating the individual's need and advocating for social and political change with longer term, wide societal impacts.

Social work and DBT: The connections

Linehan (1993) investigated why clients were not responding to other empirically validated therapies, such as Cognitive Behavioural Therapy (CBT), and what was primarily found lacking were the common therapeutic factors (Asay & Lambert, 1999; Thomas, 2007). Lack of acceptance by the therapist leading to a poor therapeutic relationship and lack of focus on commitment to therapy were primary issues. DBT overtly utilises the relationship as a core change mechanism through fully incorporating concepts of validation and acceptance, including radical genuineness on the part of the therapist, and including specific commitment and motivational strategies (Linehan, 1993).

Social work has long been correlated with a change focus of the individual, families and groups, bridging gaps in society and addressing the needs of the voiceless and disenfranchised (Ronen & Freeman, 2007). In service of this goal, psychiatric social work has often adapted models from other professions in order to provide the most effective intervention (Roberts, Yeager & Regehr, 2006). The qualified and robust social worker is therefore adaptable and outcome focused, poised to pick up evidenced-based practice to add to the array of practice principles.

DBT has grown directly out of CBT, and amplifies MacLaren & Freeman's (2007, p. xxiii) description of CBT as: '... active, dynamic, psychoeducational problem-orientated, solution-focused, collaborative, and directive'. The strength of social work is an ability to gather practical know-how from theoretical knowledge for the purpose of achieving change (Ronen, 2007). The psychiatric social worker's baseline skills thus set the scene for encompassing DBT theory and turning it into practice. Under these virtues social work appears to be an ideal profession for delivering the DBT model.

Skills similarities – Social work and DBT

Trevithick (2000) sought to clarify generalist social work practice skills and skilful interventions and published a list of 50 of these in her handbook. The authors have grouped these under headings relevant to the DBT therapist with the intention of highlighting the similarities between these generalised social work skills and the practices of DBT. This list is outlined in table one and the key factors elaborated further.

Relationship

Many social work authors and researchers have found the relationship to be the essential ingredient of best practice and delivery valuing this relationship more highly than the other skills and interventions used (Asay & Lambert, 1999; Thomas, 2007; Traux & Carkhuff, 1967 cited in Seden, 1999; Tsui, 2005; Weld & Appleton, 2008). DBT overtly uses the therapeutic relationship to create change (Linehan, 1993). The change versus acceptance dialectic requires the therapist to fully accept the client as they are and help create change. This is achieved through therapist skills of warmth, empathy, positive regard, use of self, communication and listening, skills taught in our social work training and reinforced in the practice standards of the ANZASW (Aotearoa New Zealand Association of Social Workers Inc, 2006). The importance of these therapist relationship skills has been shown in numerous research studies (Asay & Lambert, 1993; Thomas, 2007; Miller, Taylor and West, 1980).

DBT can also be viewed as an attachment and trauma-based therapy (Marra, 2005; Swenson, 2000). The therapeutic relationship aims to model appropriate attachment relationships, an experience many with BPD have not experienced. The relationship is directly attended to in the session structure providing exposure to working through the difficult factors in relationships, such as disagreements, without prematurely ending them.

Dialectics

In discussion of the bicultural practice of social work supervisors, Smart and Gray (2000) identify how the ability to hold multiple viewpoints, moving away from irreconcilable

Table one. DBT and parallel social work skills and interventions.

DBT Strategy	Parallel Social Work Skill
Use of relationship and therapy skills	<ul style="list-style-type: none">• questioning skills (four types – open, closed, what and circular) • prompting • probing • allowing and using silences • using self-disclosure • closing the case and ending the relationship • counselling skills • adaptation
Dialectics	<ul style="list-style-type: none">• mediation skills • being challenging and confrontative
Validation (from bio-social model): Level 1 Validation: Staying awake – unbiased listening and observing. Level 2 Accurate reflection Level 3 Articulating the un-verbalised emotions, thoughts, behaviour patterns Level 4 Validation in terms of past learning or biological dysfunction Level 5 Validation in terms of present context or normative functioning Level 6 Radical genuineness (of the therapist)	<ul style="list-style-type: none">• paraphrasing • clarifying • summarising • giving and receiving feedback • empathy and sympathy • offering encouragement and validation • reframing • offering interpretations
Structural strategies (structuring the therapy)	<ul style="list-style-type: none">• planning and preparing for the interview • creating a rapport and establishing a relationship • welcoming skills • sticking to the point and purpose of the interview • the role of self-knowledge and intuition • ending an interview • contracting skills • record keeping skills
Coaching and exposure – Group process	<ul style="list-style-type: none">• modelling and social skills training (authors of this article include group work) • containing anxiety
Crisis coaching skills	<ul style="list-style-type: none">• using persuasion and being directive • providing reassurance • negotiating skills • assertiveness skills • dealing with hostility, aggression and violence
Didactic strategies	<ul style="list-style-type: none">• giving advice • providing information • providing explanations
Consultation to the patient	<ul style="list-style-type: none">• providing support • providing care • empowerment and enabling skills • networking skills • working in partnership • advocacy skills • providing protection and control • managing professional boundaries
Supervision	<ul style="list-style-type: none">• reflective and effective practice • using supervision creatively
Those not identified in DBT	<ul style="list-style-type: none">• providing practical and material assistance
Source: (Linehan, 1993)	Source: (Trevithick, 2000).

opposites and either/or thinking which invalidates difference, allows us to work together effectively. Dialectical thinking is a useful paradigm to adopt in mental health social work as it provides a way to work through conflict and difference in the clinical and workplace relationships due to an acceptance that there is no absolute truth. This means that two arguments, positions or points of view that appear contradictory can be true at the same time.

A dialectical philosophy is also liberating as it accepts that the 'truth' is in constant flux, allowing one to change their position as they learn and their perspective shifts, perhaps through experience or dialogue. There are multiple 'truths' we must negotiate in social work practice emerging from our cultural, gender, sexual and spiritual identities. Dialectics means this 'acceptance of multiple meanings and constructions of the 'truth'' (Thomas & Davis, 2005, pg. 192) allowing for effective bi-cultural dialogue. An essential way to recognise a dialectic is to attempt to validate some point of view of the other, despite potentially disagreeing.

Validation through the biosocial model

Something is considered valid if it is relevant and meaningful, justifiable or logical or effective in reaching an end goal (Linehan, 1993). Validation is the act of acknowledging these things to the client, validating the individual, and identifying effective behaviour towards the agreed upon goals. This is achieved in DBT through using six levels of validation. Level one validation is the act of staying awake or present with the client through unbiased listening and observing. Level two moves into accurate reflection and mirroring while in level three the clinician articulates the un-verbalised. Level four comprises validation in terms of past learning or biological dysfunction (for example the client's behaviours make sense because of their past role-modelling or life experiences). Level five validation recognises the present context for the client and their normative functioning. For example, acknowledging that it makes sense a person is more stressed about being unemployed due to the current economic situation. Finally, level six validation is radical genuineness on the part of the therapist. This is the social worker 'being real' (Tsui, 2005; p.35) and matches with ANZASW practice standard six and the appropriate use of self. The levels of validation espoused in DBT directly map onto communication and relationship factors taught in social work and counselling training such as attentive listening and mirroring (Seden, 1999). Generally, the authors have found validation as the first treatment strategy social workers delivering DBT connect to as it is an intrinsic part of our practice and training.

As is also central in social work, DBT acknowledges the impact of the environment on the person as an essential consideration to the development of emotions and behaviours through the biosocial model (Linehan, 1993; O'Donoghue, 2004). When the goodness of fit between the individual's biological and personality make-up and their social circumstance is poor, the negative transaction invalidates the person as a whole. Smart and Gray (2000) have recognised this invalidation that occurs when a person is perceived as different within their environment. DBT targets this specifically through the use of validation. Social work, with its focus on analysis of systems through non-judgemental eyes, provides the social worker with a foundation of understanding. This understanding helps validate the intentions of those struggling to solve problems in living no matter how dysfunctional those behaviours may appear to the outside world.

In social work practice the biosocial model may be referred to as an ecological approach

or the bio-psycho-social model (Vander Zanden, Crandell & Crandell, 2007; Yassen & Harvey, 1998). Some clinicians may find Linehan's model more limited than the wider considerations of the ecological framework. However, the recognition of both biological and environmental factors allows for sound descriptions of epidemiology in a non-blaming way.

The biosocial model holds that some individuals are born with a genetic predisposition to increased emotional sensitivity, meaning they are more sensitive and reactive to emotional stimuli and recover less quickly from emotional triggers thus being more likely to remain distressed and to be re-triggered (Linehan, 1993, Miller & Rathus, 2006). This emotional sensitivity is not problematic in itself; the world needs individuals that are more sensitive (many social workers in their empathic abilities may have tendencies towards emotional sensitivity). The problem arises when this sensitivity transacts with an environment that is poorly matched to it or contains attachment disorder or trauma.

Coaching and exposure – group process

The coaching of skills in the DBT modality through a facilitated client skills group directly relates to the effects of the bio-social model. Within MidCentral DBT programmes 4-10 clients attend a weekly, two-hour group following four modules of skills: interpersonal relations, modulating emotions, becoming aware of self through mindfulness practice, and tolerating distressing situations. In adolescent programmes, caregivers also attend and an additional module of parenting and behavioural strategies is included. Modeling and social skills training is identified as inherent social work skills by Trevithick (2000), and equips the social work trained DBT therapist with effective skills coaching, essential in the model, and satisfies the re-education component of Dorland's (2007) definition of psychotherapy.

Asay and Lambert (1999) found the process aspect of group work a positive indicator of therapeutic success. Acquisition of skills aligns with the social work understanding that most people want to do better but may not have the skills or resources necessary for change. Social work training incorporates a range of modalities of treatment delivery including group and family work; both are utilised in DBT to effect change and enhance skills acquisition. The DBT skills group is another avenue in which relationships are practised and modelled.

Crisis coaching skills

Social work with training in behavioural theory and practice principles is the ideal discipline for intervening in crisis situations. Oliver & Hudson (1998), point out that most behavioural workers are psychologists and may be more removed from crisis situations as opposed to psychiatric social workers (and nurses) who they recognise as at the front line of crises and duty work. The DBT-trained social worker is positioned logically to respond to the consumer's crisis with use of coaching calls, contracts and contingency planning, using the relationship to reinforce adaptable behaviour or extinguish maladaptive behaviour. The coaching call is designed to offer support and intervention before a maladaptive coping strategy such as par-suicide is engaged, and offers timely opportunity for generalisation of skills to life outside of therapy (Linehan, 1993).

Didactic strategies

Social workers often provide information and explanations to clients to assist their understanding of the world as part of educating for change. DBT's didactic strategies and the social worker's practice principles become focused strategies. Linehan (1993) provides three scenarios, providing information, giving reading materials and giving information to family members. The thrust of didacticism in DBT is twofold, firstly it relates to influencing behavioural change within a dialectical stance, and secondly it provides validation through normalising client responses to situations (Linehan, 1993, p. 272-3).

Consultation to the patient versus consultation to the environment

A DBT adaptation to social work's traditional advocacy and community interventions is consultation-to-the-patient strategy. In essence, this strategy sets up the clinician to consult with the patient 'on how to interact effectively with her environment' as opposed to assisting the environment to interact effectively with the client (Linehan, 1993). This is consistent with ANZASW practice standard four: acting to secure client's participation in the working relationship, and also, practice standard five: assisting clients to gain control over their own circumstances (ANZASW, 2006). DBT also advocates for this by coaching clients on skills to use in their lives. However, where there are skills deficits, or the matter is essential to the person's wellbeing, the therapist can intervene.

The importance of quality supervision

In addition to the individual, family and skills group interventions for clients in DBT, DBT includes a consult group designed for staff delivering DBT (Linehan, 1993). The consult team is a form of group supervision and education that is an integral aspect of DBT. The DBT consult team recognises the high burnout rate for therapists working with BPD and other complex disorders where lability, suicidality, anger and severe trauma impact the therapists. To address this, the DBT consult both assists the therapists to provide DBT to clients and also provides DBT support to the therapist themselves (Linehan, 1993). This occurs in a structured way through use of team agreements, including agreement to maintain a dialectical philosophy, remain non-judgmental and, in the Aotearoa New Zealand context, a commitment to Te Tiriti O Waitangi. A team member provides observation to ensure these agreements are maintained.

Discussion

DBT is continuing to grow in popularity; however a strong evidence base is only one element that accounts for its rapid growth (Swenson, 2000). Other factors include a key strength that it brings together biological, behavioural, social-environmental and spiritual orientations. The psychiatric social worker is at home with these orientations and can utilise DBT to encompass the inherent change-focus of the profession and apply it in a planned, structured and moderated manner within a contracted client relationship.

While the similarities between DBT and social work have been identified, there remain limitations for social workers delivering DBT. Social workers hold a breadth of contextual understanding potentially at the expense of a deep individual formulation developed in the

training of other professions such as clinical psychology. As social workers we are becoming increasingly proficient in delivering effective DBT but there remains a requirement to balance other aspects of our clinical roles in the working week. For example both authors are additionally involved with key-working roles, duty and crises work, and delivering other therapies. The workload for social workers is often increased when delivering DBT, a comprehensive and time-intensive therapy, becoming problematic if this is not recognised by supervisors and managers.

It may be argued that DBT brings nothing new to the fore for therapy or social work, rather a unique combination of therapy strands. This may be true; however, it is useful in its gathering together of these concepts and formulating them into a clear theory and model of practice for previously difficult to treat populations (Marra, 2005). DBT has also been experienced by some as too prescriptive. However, the therapy allows for eclecticism as ancillary treatments are able to be put in place alongside DBT where indicated (Marra, 2005). Flexibility is the core of a dialectical paradigm that avoids holding too tightly to one process.

Linehan herself outlines the problems inherent in her therapy (1993). She identifies that it takes too long, but perhaps all therapies take too long when clients are sitting with high levels of pain on a day-to-day basis. DBT is also a high resource investment in terms of cost and time for agencies because it is an intensive therapy with multiple delivery modes. However, people with the intensity of problems that DBT address require this intensive input. Further studies that give more indication as to which modes of DBT have the largest impacts will allow for these resources to be directed more efficiently. For now the experience is that DBT is so effective because it is delivered through multiple modes that consider the needs of the client, family and clinicians.

Numerous reviewers have attended to research that outlines core factors in mental health therapy that exist irrespective of the therapeutic model. Many of the factors identified are common to the philosophies both of social work and DBT including centrality of relationship, client strengths and resources, group process, and client motivation and commitment. Current empirical findings show therapist qualities of warmth, positive regard, validation and genuineness enhance outcomes. Social workers are therefore in a wonderful position to create change as the DBT paradigm aligns well with social work and with appropriate additional training and support. We should be encouraging and supporting one another to utilise these strengths.

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